Division of Licensing and Protection

P0003/0005 F-046 PRINTED: 09/10/2015 FORM APPROVED

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	R-C 08/26/2015	
	0155		B, WING		
NAME OF S	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE YID CODE	
	·	242 NOE	ODRESS, CITT. ST RTH PROSPECT	·	
ST JOSE	PH'S RESIDENTIAL (IARE HOME	GTON, VT 0540		
(X4) ID PREFIX TAG	 (EACH DEFICIENCY 	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
{R100}	Initial Comments:		{R100}		
	by the Division of Li 8/26/15 as a follow which regulatory vio complaint investiga conjunction with the no regulatory violet complaint. The follor resulted from the fo				
(R126) SS≕D	V. RESIDENT CAR	RE AND HOME SERVICES	{R126}	•	
 	5.5 General Care				
	residential care hor be provided or arra	ent's admission to a me, necessary services shall nged to meet the resident's ocial, nursing and medical care			
	by: Based on staff inte home failed to prov applicable resident	NT is not met as evidenced rview and record review the vide supervision of 1 of 2 in a manner to assure the I safety needs were met.			
and the second s	(Resident #1). Find	dings include: staff failed to adequately			
Division of Li	his/her subsequent the home for a per and 40 minutes, wi resident's most red identified him/her v	n of Resident #1, which led to telopement and absence from telopement and absence from iod of approximately 3 hours without staff knowledge. The cent assessment, dated 3/5/15 with moderate impairment in bility for daily decision making.		TITLE	(XA) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

If continuation sheet 1 of 3

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NAME OF PROVIDER OR SUPPLIER STANDARD OF PROVIDER OR SUPPLIER O155 SUMMARY STATEMENT OF DEPROSPOSES TO JOSEPH'S RESIDENTIAL CARE HOME SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 SUMMARY STATEMENT OF DEPROSPOSES FRAM DEPROSPECT STREET BURLINGTON, VT 05401 FROMDERS PLAN OF CORRECTION FROM DEPROSPECT STREET BURLINGTON, VT 05401 FROM DEPROSPECT STREET BURLINGTON, VT 05401 FRAM DEPROSPOSED STATEMENT OF CONSTRUCTION OF CONSTRUC	Division	of Licensing and Pro	ptection		• •	FORMAPPROVED
SAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZP CODE	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		· ·			
ST JOSEPH'S RESIDENTIAL CARE HOME 243 NORTH PROSPECT STREET BURLINGTON, VT 05401 (K126) Continued From page 1 A Care Plan Conference was held on 4/16/15 and indicated the resident was at risk. "Because [she] loves to walk [srhe] is at risk of walking off the premises and getting lost." The record revealed the resident had a history of wandering as evidenced by hisfner disappearance on 5/21/15 when she had gone for a walk and was returned to the home approximately 2 hours later by police after staff had been unable to locate him/her. Despite this identified risk a subsequent progress note indicated that on the night of 6/16/15 at 11/50 PM local police had contacted the home to notify staff they had found the resident wandering a distance from the home. The note further indicated that staff had no feal the resident had eloped or how long s/he had been missing from the home. During interview the DNS (Director of Nursing Services) stated that rounds are conducted by both an off-going and an on-coming categiver, together, at the charge of every shift to dotsmine presence of each of the residents. However, although both the caregivers had documented the presence of Resident #1 had obtomed that resident rounds had been conducted every two hours during the 8/16/16 woning shift, in accordance with the home's policy, the DNS and the Administrator both acknowledged that per review of a video recording it was determined that resident #1 had exited the facility without staff knowledge at approximately 8 10 PM and was not returned until approximately 8 3 bauss and 40 minutes later, indicating a failure, by staff to adequately supervise/memory the resident.		·	0155	B. WING	·	
ST JOSEPH'S RESIDENTIAL CARE HOME 243 NORTH PROSPECT STREET BURLINGTON, VT 05401 PREFIX TAG STAMMANY STATEMENT OF DEPICIENCIES PROVIDERS PLAN OF CORRECTION REQUIRED PROVIDERS PLAN OF CORRECTION RECOMPLIST REQUIRED PROVIDERS PLAN OF CORRECTION RECOMPLIST RE	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	of the state of th
RREGULATORY OR LOS DEMINIFYING INFORMATION) (R126) Continued From page 1 A Care Plan Conference was held on 4/16/15 and indicated the resident was at risk; "Because [s/hel loves to walk [s/hel] is at risk of walking off the pramises end getting lost". The record reveeled the resident had a history of wandering as evidenced by his/her disappearance on 5/2/115 whon s/he had gone for a walk and was returned to the home approximately 2 hours later by police after staff had been unable to locate him/her. Despite this identified risk a subsequent progress note indicated that on the night of 3/16/16 at 11:50 PM local police had contacted the home to notify staff they had found the resident wandering a distance from the home. The note further indicated that staff had no idea the resident wandering a distance from the home. The note further indicated that staff had no idea the resident may be both an off-going and an on-coming caregiver, together, at the change of every shift to determine presence of Resident #1 during the 11:00 PM shift change rounds on 8/16/16, both caregivers later secknowledged they had not physically seen the resident at that time. In addition, despite the fact that a caregiver had documented that resident rounds had been conducted every two hours during the 8/16/16 evening shift, in accordance with the home's policy, the DNS and the Administrator both acknowledged that per review of a video recording it was determined that Resident #1 the was determined that Resident #1 the home's policy, the DNS and the Administrator both acknowledged that per review of a video recording it was determined that resident #1 had exited the facility without staff knowledge at approximately 8:10 PM and was not returned until approximately 3: hours and 40 minutes later, indicating a failure, by staff to adequately superyies/monitor the resident.	ST JOSEPH'S RESIDENTIAL CARE HOME 243 NORTH PROSPECT STREET					
A Care Plan Conference was held on 4/16/15 and indicated the resident was at risk; "Because (s/hel) loves to walk (s/he) is at risk of walking off the premises and getting lost". The record revealed the resident had a history of wandering as evidenced by his/her disappearance on 5/2/1/15 when s/he had gone for a walk and was returned to the home approximately 2 hours later by police after staff had been unable to locate him/her. Despite this identified risk a subsequent progress note indicated that on the hight of 8/16/15 at 11:50 PM local police had contacted the home to notify siaff they had found the resident wandering a distance from the home. The note further indicated that staff had no idea the resident had eloped or how long s/he had been missing from the home. During interview the DNS (Director of Nursing Services) stated that rounds are conducted by both an off-going and an on-coming caregiver, together, at the change of every shift to determine presence of each of the residents. However, although both the caregivers had documented the presence of Resident #1 during the 11:00 PM shift change rounds on 8/16/16, both caregivers had documented that resident at that time. In addition, despite the fact that a caregiver had documented that resident trounds had been conducted every two hours during the 8/16/16 evening shift, in accordance with the home's policy, the DNS and the Administrator both acknowledged that per review of a video recording it was determined that Resident #1 had exited the facility without staff knowledge at approximately 8/10 PM and was not returned until approximately 8/10 PM and was not returned unt	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE COMPLETE
indicated the resident was at risk; "Because [s/he] loves to walk [s/he] is at risk of walking off the premises and getting lost." The record revealed the resident had a history of wandering as evidenced by his/her disappearance on 5/21/15 when s/he had gone for a walk and was refurned to the home approximately 2 hours later by police after staff had been unable to locate him/her. Despite this identified risk a subsequent progress note indicated that on the night of 5/16/15 at 11:50 PM local police had contacted the home to notify staff they had found the resident wandering a distance from the home. The note further indicated that staff had no idea the resident had eloped or how long s/he had been missing from the home. During interview the DNS (Director of Nursing Services) stated that rounds are conducted by both an off-going and an on-coming caregiver, together, at the change of every shift to determine presence of each of the residents. However, although both the caregivers had documented that resident at hat time. In addition, despite the fact that a caregiver had documented that resident at that time. In addition, despite the fact that a caregiver had documented that resident at that time. In addition, despite the fact that a caregiver had documented that resident at that time. In addition, despite the fact that a caregiver had documented that resident at that time. In addition, despite the fact that a caregiver had occumented that resident at that time. In addition, despite the fact that a caregiver had documented that resident founds had been conducted every two hours during the 8/16/16 bett caregivers atter acknowledged they had not physically seen the resident at that time. In addition, despite the fact that a caregiver had occumented that resident founds had been conducted every two hours during the 8/16/16 bett caregivers are not here we do hourly caregiver had obtained the fact that the caregivers had occumented that resident founds had been conducted every two hours during the 8/16/16 bett caregi	(R126)	Continued From pa	ge 1	{R126}	THE STATE OF THE S	
		SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 A Care Plan Conference was held on 4/16/15 and indicated the resident was at risk; "Because [s/he] loves to walk [s/he] is at risk of walking off the premises and getting lost". The record revealed the resident had a history of wandering as evidenced by his/her disappearance on 5/21/15 when s/he had gone for a walk and was returned to the home approximately 2 hours later by police after staff had been unable to locate him/her. Despite this identified risk a subsequent progress note indicated that on the night of 8/16/15 at 11:50 PM local police had contacted the home to notify staff they had found the resident wandering a distance from the home. The note further indicated that staff had no idea the resident had eloped or how long s/he had been missing from the home. During interview the DNS (Director of Nursing Services) stated that rounds are conducted by both an off-going and an on-coming caregiver, together, at the change of every shift to determine presence of each of the residents. However, although both the caregivers had documented the presence of Resident #1 during the 11:00 PM shift change rounds on 8/16/15, both caregivers later acknowledged they had not physically seen the resident at that time. In addition, despite the fact that a caregiver had documented that resident rounds, had been conducted every two hours during the 8/16/15 evening shift, in accordance with the home's policy, the DNS and the Administrator both acknowledged that per review of a video recording it was determined that Resident #1 had exited the facility without staff knowledge at approximately 8:10 PM and was not returned until approximately 3 hours and 40 minutes later, indicating a failure, by staff to		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY) - As of 8/20/15, we have char activation time of our door ala from 9:00 pm to 8:00 pm. We had our alarm system vendor, system testing from weekly to - As of 8/20/15 we have confr Care Trak Northeast, to use a system to locate Resident 1 she elope. The Burlington Police has the locator device. - As of 8/30/15 Resident 1 had duty from 4:00 pm-8:00 pm 7 d When the private duty care given the week of hourly checks. To hourly checks are being completely the both sign the assignment sheet attached) attesting that the che other tasks were completed. These hourly verifications will until Resident 1 has found other placement. - We are actively seeking nursiplacement and have requested guardian to help Resident 1 madecisions. We also are looking VNA adult day program as an Resident 1. - Both employees were given a action plan for not checking rechange of shift and documenting was complete and he was in be		larm system Te have also r, increase the to daily, attracted with a GPS tracking should he e Department las 1:1 private days a week, givers are not o ensure that pleted, Med hourly and et (see necks and ill be on-going her rsing home d a legal make ng into the n option for a corrective resident at ting that it bed, [1]

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STATEMEN AND PLAN	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IER/CLIA UMBER:	(X2) MULTIP		(X3) DATE SURVEY COMPLETED	
· · · · · · · · · · · · · · · · · · ·	0155			8. WING	R-C 08/26/20	R-C 08/26/2015	
NAME OF PROVIDER DR SUPPLIER STREET ADD					DRESS, CITY, STATE, ZIP CODE		
ST JOSE	PH'S RESIDENTIAL (CARE HOME		TH PROSPE STON, VT 05			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE COL REAPPROPRIATE	(XS) MPLETE DATE
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	This is a repeat de	eficiency ,			at 3:38 Pm m	9/24/15 19/	34/
					at 3:38 pm on Completion date Bonnie	for POCY	115
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